

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005971	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/12/2015
NAME OF PROVIDER OR SUPPLIER REHABILITATION HOSPITAL OF INDIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4141 SHORE DR INDIANAPOLIS, IN 46254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This survey was for the investigation of one (1) State complaint.</p> <p>Complaint number: IN 00149223 Unsubstantiated; lack of sufficient evidence</p> <p>Date: 02/12/2015</p> <p>Facility number: 005971</p> <p>Surveyor: Nancy Otten, RN, Public Health Nurse Surveyor</p> <p>Rehabilitation Hospital of Indiana is in compliance with 410 IAC 15-1.4-1, Governing Board Responsibilities, 410 IAC 15.1.5-2, Infection Control and 410 IAC 15-1.5-5, Medical Staff, Hospital Licensure Rules.</p> <p>QA: cloughlin 03/16/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE